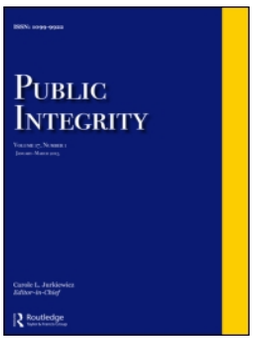
Integrity in Public Life: Reflections on a Duty of Candour

Journal Item



Public Integrity

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/mpin20

Integrity in Public Life: Reflections on a Duty of Candour

Simon Gardiner, Douglas Morrison & Simon Robinson

To cite this article: Simon Gardiner, Douglas Morrison & Simon Robinson (2021): Integrity in Public Life: Reflections on a Duty of Candour, Public Integrity, DOI: 10.1080/10999922.2021.1903165

To link to this article: https://doi.org/10.1080/10999922.2021.1903165

Published online: 10 May 2021.

Public Integrity, 0: 1–12, 2021

ISSN: 1099-9922 print/1558-0989 online
DOI: 10.1080/10999922.2021.1903165

Routledge
Taylor & Francis Group

Integrity in Public Life: Reflections on a Duty of Candour

Simon Gardiner

The Open University

Douglas Morrison and Simon Robinson

Leeds Beckett University

This article will evaluate whether a "duty of candour" on public employees including specifically health practitioners and police officers is an effective mechanism in terms for improving trust and openness. This is the context of the actions of the police in relation to the Hillsborough Stadium disaster in 1989 where 96 soccer fans died at the match due to ineffective policing. The formal identification of responsibility on the part of the police despite the attempt by the police to attribute blame elsewhere, was the starting point of a proposal for an explicit duty on officials in public bodies such as the police to tell the truth and be under a statutory "duty of candour." The article provides an overview of the duty of candour, its subsequent development, legislatively and professionally in the context of the British health care system, where it currently exists, and the potential impact for the police. It is argued that engagement with the paradox between professional and organizational duty expressed through the language of culture and truth telling is necessary to reassert the importance of trust and integrity in a range of public bodies.

Keywords: Duty of Candour, integrity, organizational culture, trust

INTRODUCTION

Trust in public bodies, officials, and professionals is at best tarnished and at worst a cliché (Case, 2017). The publication of high-profile inquiries in the United Kingdom into events at Hillsborough (Taylor, 1989), Ashworth (Fallon, 1999), Alder Hey (Redfern Michael, 2001), Bristol (Kennedy, 2001) McLean, Issacs (Metters, 2003), Mid-Staffordshire (Francis, 2013a) and Morecambe Bay (Kirkup, 2015) are the tip of an increasingly visible iceberg. Whilst arguments of regulatory deficiencies or failure permeate most of these inquires, what also is evident is the reticence on the part of said bodies and more specifically professionals

Correspondence should be sent to Simon Gardiner, The Open University, Milton Keynes, UK. E-mail: simon.gardiner@open.ac.uk

employed therein, to step forward when poor performance, or poor practice occurs (Case, 2017). In addition, the inquiries references to so called "bad apples" (Francis, 2013a, p. 315) or 'not bad people,' (Kennedy, 2001, p. 268) misses the reality, which is in fact a professional culture, discipline aside, in which concealment appears to be the default position, and disclosure or whistle blowing is met with exclusion, dismissal or compromise agreements (Martin, Chew, & Dixon-Woods, 2019). Many of the above formal inquires involve failures in health provision, a long additional list could be presented concerning the actions and apparent and established failures of other public or quasi-public bodies. More recently the Covid-19 pandemic, has revealed further issues around trust, openness and candour, not only in relation to Government communication, but again in relation to health and social care. A key concern has been hospitals returning patients to care homes without informing them the patient was positive to coronavirus (Hill, 2020).

This article will evaluate whether a 'duty of candour' on public employees including specifically health practitioners and police officers is an effective mechanism in terms for improving trust and openness. This is the context of the actions of the police in relation to the Hillsborough Stadium disaster (the ground of Sheffield Wednesday Football Club (FC)) in Sheffield in the north of England in 1989 where 96 soccer fans died due to being crushed primarily caused by overcrowding at the match (HIP, 2012). The false narrative spun by the police force putting the blame centrally on the disorder of football fans at the match, succeeded in obfuscation of the events surrounding the Hillsborough disaster (Jones, 2017), and explains the delay in setting up an independent inquiry. After many years of inertia involving legal hearings and public scrutiny, the UK government instituted the Hillsborough Independent Panel (HIP) concluded that no football fans were responsible in any way for the disaster. The cause was a "lack of police control" (HIP, 2012, p. 203), with crowd safety "compromised at every level" (HIP, 2012, p. 319). These findings were the catalyst for a proposed explicit duty on officials in public bodies such as the police to tell the truth and be under a statutory "duty of candour." The Public Authority Accountability Bill to introduce this duty was introduced in the UK Parliament in 2017, but due to the general parliamentary election in that year did not progress to become an Act of Parliament. There continues to be significant support for this so-called 'Hillsborough Law' to be re-introduced and enacted in the future (Conn, 2019).

A duty of candour should be differentiated from acting as a whistleblower. It is a positive duty to be tell the truth and should also be distinguished from laws criminalizing forms of misconduct in public office or duties that specific individuals to actively report misconduct of work colleagues. Candour involves a positive requirement to be actively truthful rather than merely criminalizing conduct, such as with perjury, when it can be proven that an individual has been dishonest within specific legal procedures. A duty of candour does have similarities with the requirements that officers of the law have in many jurisdictions to share material information in legal proceedings. But it goes beyond these confines to a wider holistic requirement on public officials to be open and truthful.

It is therefore against this backdrop of error, cover up, lack of transparency and failure to learn in a number of settings that this paper will now turn. Its aims are to provide an overview of the duty of candour, its subsequent development, legislatively and professionally in the context of the British health care system and the National Health Service (NHS), along

with subsequent critiques, before considering its potential impact for the police, using Hillsborough as a lens. Once complete, what will be revealed is that the duty of candour is far from new, and that whilst its subsequent development in the context of the NHS and its subsequent application to the police may be welcome, it is but one step, and not the panacea sought. Indeed, it is proposed that what is needed is a change in organizational culture (Jones, 2017), a view echoed by the Francis Report (2013a), but more importantly the embracing of what can be termed 'integrity in public life.' It is this and its various constituent elements, which it is argued, will reassert the importance of trust, in a range of public bodies including the health service and the police. In light of that it is the purpose of this work to initiate and ferment that conversation.

CANDOUR AND HEALTH AND CARE

An examination of issues that have arisen in the British health service is an instructive starting point. It is clear, at least rhetorically, that in the setting of health and social care, and therefore public bodies per se, that an organizational or professional duty to disclose relevant information, to be candid is essential and not really a choice. In reality however, the number of inquires undermine that proposition, revealing organizational as well as professional failures and cover up, extending back to at least to 1952 and the Corneal Grafting Act. In more recent times, the Bristol inquiry initially convened to deal with whistle blowing into the high rates of death associated with paediatric cardiac surgery, also revealed the subsequent non-consensual retention of children's organs and tissues. The Bristol Interim Report noted that there had been a "lack of openness and honesty" with parents (Kennedy, 2001, p. 139) and the existence of a "club culture" amongst the profession. A view echoed by the Alder Hey inquiry, which noted that parents felt the medical profession had been "dishonest and patronising," (Redfern Michael, 2001, p. 400) with both inquires concluding that events indicated both professional and organizational collusion, and inaction (Redfern Michael, 2001, Kennedy, 2001). Somewhat presciently, in light of the Francis Report (2013a), the Alder Hey inquiry recommended that a what was needed was a "culture of respect, honesty and openness within … healthcare" (Redfern Michael, 2001, para. 46, p. 298). This duty of candour combined a policy for reporting relevant incidents including admission of mistakes even if legal liability might arise (Redfern Michael, 2001, para. 51: 298).

Despite such unequivocal critiques and a clarity on what was needed, change was slow and whilst the introduction of the Health and Social Care Act 2008, created a new regulatory body in the Care Quality Commission (CQC) (n.d.) to regulate the professions and emphasizing the need for quality and organizational responsibility, there was no mention of a statutory duty of candour. This absence or reluctance to impose such a duty was echoed in the Berwick (2013) Report which failed to recommend the introduction of a statutory duty for healthcare workers. The opinion was that such a duty was covered by professional regulations, a position supported by the then government, despite historical evidence to the contrary. The implications of this lacunae summed up by Walsh (2020), in that "no NHS organization was in breach of any statutory regulation or law if it covered up incidents which had harmed or even killed patients."

The turning point was the Francis (2013a) Report the remit of which was to investigate claims of poor care linked with high mortality rates in the NHS region, the Mid Staffordshire Hospital Trust. What emerged was a similar narrative as to past reports in that harmful patient incidents, whilst frowned upon were simply covered up. Concepts such as trust, honesty and integrity were identified as being at breaking point, thus leaving one to conclude that the factionalism and so called "club culture" continued unabated. Building on some of the points of Alder Hey, Francis noted that "it is far more effective to learn rather than to punish. To place too much emphasis on individual blame … will perpetuate the cycle of defensiveness, concealment, lessons not being identified and further harm" (Francis, 2013a, p. 41). Although laudable comments, it is proposed previous inquires undermine such sentiments. The Francis Report made 290 recommendations, covering areas of leadership, management, communication, governance, standards of behavior, institutional, and professional defensiveness, as well as the need of openness, transparency and candour (Francis, 2013a, p. 83).

Following the publication of the Francis Report, the government imposed a statutory duty of candour on organizations, founded on the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014, section 3. The duty was then extended to all CQC providers in 2015 and required under regulation 20, that any event causing death, severe harm, moderate harm, or prolonged psychological harm must be notified by the organization and investigated. This statutory duty, although placing a duty on the organization, did not place a legal duty on health care professionals to report their own colleagues misconduct. In light if this lacuna, the General Medical Council (GMC) and the Nursing Midwifery Council (NMC) NMC and GMC (2020), along with professional regulators, such as the National Health Litigation Authority (NHLA) and National Reporting and Learning Systems (NRLS), published a joint statement. This set out a professional duty of candour, in essence to be open and honest with patients when things go wrong with their care, including advice and apologies (NMC/GMC, 2013). Viewed in this way, the duty could be seen to be a more holistic approach to the duty of candour. However, despite this important differences remain. For example, for the purposes of the organizational duty, regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is primarily process driven indicating the harm thresholds that should trigger the duty and applies only to situations referred to as notifiable safety incidents. In contrast, the professional duty to be open and honest when mistakes occur, applies to all situations and is vested in the individual practitioner, or registered person and extends to reporting adverse events, that may cause harm, lead to harm or are simply a near miss. This means there will be some situations where the professional duty applies, but the statutory threshold will not be met for the imposition of a legal duty on the organization.

This reveals an interesting paradox, in that although the duties are thematically the same, the professional duty will not trigger the threshold for the statutory duty (Hopwood, 2020), and as such they are neither discrete nor consistent. Interestingly, although anecdotal evidence indicates the statutory duty has been welcomed by professions and managers as empowering, its subsequent implementation has been seen more as a tick box exercise, rather than an opportunity to be candid and reflect on poor practice (Walsh, 2020). In relation to this article, it is this paradox between professional and organizational duty expressed through the language of culture and truth telling that this work will return. However, prior to that it will consider the impact of the duty of candour on the police, and in particular

the Hillsborough stadium disaster, before then sketching out an overarching and it is argued, a more profound, concept and duty, premised on truth and the idea of 'integrity in public life.'

THE HILLSBOROUGH DISASTER

Whilst the overcrowding at the Hillsborough football stadium and subsequent deaths and injuries were for some time partially blamed on fan behavior, the deceased and relatives who coalesced into a pressure group, the Hillsborough Families Support Group (HFSG), clearly thought otherwise. It was their tenacity to find the truth that has driven their campaign for accountability. Indeed, the real reasons behind the disaster began to emerge soon after the disaster at least partially, through a formal government inquiry, which indicated "although there were other causes, the main reason for the disaster was the failure of police control" (Taylor, 1989, p. 49). Subsequently, and perhaps more damingly, a profession which relies on public confidence and 'policing by consent,' was found at senior level to have coerced junior officers to alter their notes, or to have written/altered them for them fabricating responsibility for the disaster primarily on fan behavior. Such deception was further exacerbated by the South Yorkshire Police Force's reluctance to accept responsibility, and to prevaricate and hinder subsequent legal processes (Scraton, 2016). The process of establishing who was responsible for this overcrowding at the match and apportion responsibility has been protracted and tortious.

With the assistance of academic research (Scraton, 2016), HFSG persuaded the government in 2009 to allow access to public records routinely restricted for a 30-year period. Then in 2010 the Hillsborough Independent Panel (HIP) was convened comprising of 12 expert lay people under the Chair of the Bishop of Liverpool. Reporting its analysis in 2012, the police and other emergency services together with Sheffield Wednesday FC were identified as being responsible for the deaths of the 96 victims. In December 2012, the original decision of accidental death from the Coroners Inquest 1989–1991 was set aside by the High Court and a new Coroner's Inquest for every victim commenced in 2014. Verdicts were reached in 2016 and the deaths were determined as being unlawful killings.

Further reports followed which focused on the families' experiences of the 30 year period, and the second how public bodies and specifically the police can disconnect from formal procedures and actively seek to discredit and distort findings (Jones, 2017). This was illustrated during the second Coroners Inquest from 2014 to 2016, where lawyers acting on behalf of the South Yorkshire Police, cross-examined family members in an attempt to discredit their testimony. Echoing the findings of the HIP, this 2017 report called for the creation of a duty of candour. In the case of the police force this was a general duty of candour to apply to all officers, serving or retired. In 2017, a Private Members Bill proposed by an indivdual Member of Parliament, entitled the Public Authority Accountability Bill (the so-called 'Hillsborough Law'), was introduced in Parliament. Although passing its first hearing, the Bill made no further progress and was extinguished by the 2017 UK general election and subsequent events. The Bill proposed the creation and implementation of a duty on public authorities, to at all times, act within 'the public interest, to be transarent candid and frank' as well as a duty to assist court proceedings, inquiries, and official investigations. The central

assertion promulgated is the need for the incorporation of a statutory, contractual, and professional duty of candour as a means of underpinning and directing police behavior and/or practice.

It is these findings of delay and obfuscation in the proceses in the aftermath of the Hillsborough disaster that resonates with the themes indentified within the various NHS inquires discussed earlier. This is the genesis for an overarching legislative duty, in line with the professional duty, for the police and all public bodies to tell the truth. However, it is the main contention of this article that the complex duty of candour outlined earlier would result in the same delays and problems. In light of that, the contention is that there is a prerecquisite to seek and encourage a more profound cultural shift both organizationally and professionaly, a shift clearly needed in light of continuing events by outlining the ingredients/characteristics of what we term "integrity in public life," the first of which is that of trust.

CONSTITUENTS OF CANDOUR

An examination of the history and elements of candour is instructive with trust, recognised as a major driver of the development of a recognised duty of candour in Britain. This will be carried out in two ways: firstly, the legal antecedents of this type of duty and secondly, the philosophical foundations. Historically, at common law in Britain, or at least in the context of public law and judicial review, the duty of candour is far from new. In terms of the development of the importance of trust and the common law offence of misconduct in a public office, it was held in *R v Bembridge* (1783) 3 Doug KB 32 (para 57) that where those holding public office ' … carry out their duties for the benefit of the public as a whole … if they abuse their office, there is a breach of the public's trust'. More recently the Court of Appeal, in *Attorney General's Reference No 3 of 2003* (2004) EWCA Crim 868 [para 61], outlined the elements of the offence: a public officer acting as such; wilfully neglects to perform his duty and/or wilfully misconducts himself; to such a degree as to amount to an abuse of the public's trust in the office holder; without reasonable excuse or justification. Additionally, in the context of judicial review these elements are evident in cases such as *R v Lancashire County Council, ex parte Huddleston* [1986] 2 All ER 941, where Lord Donaldson stated that it is for public servants to 'explain fully what has occurred and why (para 945)'. In other words a duty to act with transparency, honesty, and integrity in the disclosure of pertinent information to the courts and thereby engender trust, in essence to be candid.

The concept of candour is based on the foundational virtue of honesty or truthfulness (*Alethia*, Aristotle, 2004), and as such is a key part of personal, professional or organizational integrity, based in the interconnected identity and purpose of each of these. Its practice requires other virtues, such as the capacity for justice, respect, and related empathy, courage and mindfulness, each, in this context, involving awareness of the self in relation to others. Critical to the practice of such virtues and thus of integrity, is the practice of responsibility, and this is again more complex than a simple duty. This suggests a more complex view of integrity than standing up for certain principles such as honesty. One example of this is set out by Gardiner et al. (2017) and Robinson (2016) where the three interconnected modes of

responsibility are presented as the basis of integrity. These can be usefully examined in the context of the NHS.

First, agency, involving autonomy (self-governance) and clarity about purpose and practice. In effect taking responsibility for ideas and action, including competent practice. The first of these modes demands strong critical reflective practice and owning the overall vision of healthcare. Hence, the strong emphasis in the NHS Constitution, (2015) on the core NHS vision and responsibility of all stakeholders. The focus is on the wider common good, not discrete aspects of this.

Second, accountability, involving both plural accountability (to many different 'stakeholders,' patient, profession, healthcare organization, and so on) and mutual accountability, between carers and cared for, between professions, in organizational structures, and so on. The complexity of the health service is revealed. The medical or nurse practitioner is focused not simply in discrete duties to patients but in accountability to the profession (for the integrity of that profession) and to the employing organization. It is more generally to the wider healthcare project (in the UKs' case the NHS, as belonging to the people' (NHS, 2015, p. 1) including any government framed healthcare and regulators, to other professions and professionals who they need to achieve quality of care, and accountability to all of these stake holders for how key values and principles are maintained. In turn, each of these stakeholders is accountable to the particular professions, to give them support and resources to fulfil their roles and responsibility. Hence, the different professions, and different levels, or leadership are mutually accountable for the quality of care, something recognised in the development of clinical governance (Robinson & Doody, 2021).

Third, positive responsibility (Ricoeur, 2000), involving the practice of the moral imagination focused in shared responsibility and on developing possibilities for positive practice. This involves negotiation about how best to fulfil responsibility for the whole project and the particular responsibility of each profession necessitating the exercise of imagination and thus the generation of possibilities. A good example of this in public health is Amsterdam's response to childhood obesity (Amsterdam Approach to Healthy Weight (AAGG) City of Amsterdam, 2015). This project developed a learning organization across the city including all stakeholders, and the capacity to respond to a changing social environment. The failures in the Mid-Staffordshire case (Francis, 2013a) precisely involved absence of any of these modes of responsibility. Responsibility for the core purpose of care, and even competence, was avoided by some members of core professions because finance and institutional sustainability, and related targets, dominated practice. This was reinforced by a lack of plural or mutual accountability across the piece. Professionals were focused into accountability to the administration, which in turn led to hyper-accountability (Thompson & Bevan, 2013). In turn, many of these professionals lost any sense of accountability to patients and families. Professional bodies saw their accountability in terms of defending members. Several regulators did not see themselves as accountable to the wider project for pushing through critical questions. None saw their responsibility for the whole project of healthcare.

The defensiveness noted by Francis (2013a) was precisely because of a dynamic of conflict. This dynamic was not a simple matter of covering up the bad practice but was rather endemic to a narrow managerial stance. Different stakeholders who questioned purpose,

objectives and practice were viewed neither as part of a team, and thus shared resources, nor as representing need (either of the workforce of the patients), but as threats to institutional success and thus to organizational identity. Hence, patients, families, colleagues, and professional bodies who complained were seen as "nuisances," in effect diminished and discounted, with their voices not heard (Robinson, 2013). This same dynamic extended to whistleblowing, which was seen as an attack on the Mid Staffordshire Trust and the provision of care (Robinson & Doody, 2021). Ironically, this attack was reinforced by some public attacks on whistle blowers who were perceived as endangering local hospital provision.

In seeking to address the aforementioned issues, it must be remembered that 'that every system is perfectly designed to deliver the results it produces … (Batalden cited by Carr, 2008). Viewed through the lens of Francis, the results were inculcation of a 'culture of corporate self-interest and cost control over patients and patient safety' (Francis, 2013b). In seeking to address such failings and therefore change the system, Francis's recommendations, amongst many, calls for the 'beginning of a journey towards a healthier culture in the NHS,' (Francis, 2013b) or as we prefer, unfinished business and the development of an organizational culture, underpinned and driven by both candour and trust. The pressure of a culture of fear, reinforced by negative responsibility (blame cf. Francis, 2013b), precisely discouraged the practice of virtues (Moore, 2012). This view finds support from psychology and the so-called bystander effect (Sanderson, 2020). Sanderson notes four reasons why people do not engage in a crisis: uncertainty about what is happening; lack of a sense of personal responsibility; misperception of social norms (including ethical principles); and fear of consequences. It is important not to underestimate the power of these dynamics, including for some professionals a fear of the loss of their professional identity and status, to say nothing of income.

A GENERAL STATUTORY DUTY OF CANDOUR?

The experience of a statutory duty of candour in the health service provides a stark guidance for its creation for wider public officials including the police. The danger of relying on a statutory duty of candour in this context is that it once more creates a culture of fear, of responding to regulation without engaging responsibility at any level. An analogy can be made with the third King report (King, 2009) on governance which noted similar dynamics in terms of US legislative approaches to corporate governance and corporate social responsibility. In this, the law demanded that codes of ethics be developed. The result was a proliferation of codes (hitting the target), but little actual engagement with meaning. It was simply a box ticking exercise of management, style over substance. The same dynamic could easily be found in healthcare management without attention to the development of responsibility at every level.

Such arguments suggest that the development of a culture of integrity which is both supportive and challenging has to go hand in hand with any statutory duty. Such a culture demands the development of responsibility in all the modes. The focus on responsibility for purpose demands an ongoing narrative which reinforces that purpose at all levels of decision making, practice, and communication. The focus on plural and mutual responsibility demands critical dialogue and, with that, attention to an architecture of listening, as a formal part of

the culture. As MacNamara (2015) notes, many leaders assume that their communication is dialogic, whereas empirical evidence suggests otherwise. That very assumption confirms a lack of critical reflection about professional identity and practice. The integrity of the healthcare project at Mid-Staffordshire Trust required dialogue with many different organizations and professions who were involved, including concern about the sustainability of the Trust, concern for the quality of care, and concern about relationships with patients and families. In effect this involved the need for a complex inter-institutional integrity, involving: individuals taking responsibility for their practice and for the meaning and practice of their profession, their organization, and the overall health project; professions taking responsibility for their task and for the overall project; and different stakeholders, including regulators and government taking responsibility for role fulfilment and for the overall project.

However, the recent history of policing in the UK shows very specific dynamics of conflict and absence of a culture of integrity, from the "political" role of the police in the miners strike in the early 1980s (Green, 1990), racial profiling in stop and search powers and border security (Wood and Gardiner, 2019) to unlawful undercover operations (UCPI, 2015). All of these situations in different ways can be characterised by conflict between the police and the public, development of counter-narratives justifying policing strategy and practice and distortion of truth when serious incidents occur and reviews take place resulting in low levels of trust of the police. Viewed from this perspective, it is clear that a duty of candour would have a huge impact on the police force in any future Hillsborough scenario and their general service. In the context of the police, it is clear that the impact of this duty would be to provide all information and materials to survivors of Hillsborough and or the victims representatives. In essence to be open and honest, which conflicts with traditional organizational cultures of police. This is characterised as a closed inward looking focus with a hightented notion of the "police's solidarity, which may tolerate corruption and resist reform" (Waddington, 2008). This is not easy to reconcile with police engagement with the public where British policing is predicated on a concept of policing by consent and procedural justice theory and psychological responses of the public to regulatory regimes. Within policing studies, this theory necessitates that perceptions of legitimacy on the part of citizens' subject to such regimes requires two components, firstly, effectiveness of police conduct and secondly, the active engagement of the police with the public (Brouwer et al., 2018). For this to be a reality, this would seem to be necessarily predicated on openess and trust.

Central to this is the development of a learning organization (Senge, 1990). This might include: cultural (including ethical) audits, focused on how responsibility is practised; interprofessional training, focused on shared responsibility; reflective practice focusing on how professions and management fulfilled the core purpose of care, and the development of a shared narrative of care; ensuring that KPIs (even of figures about numbers of apologies) are not used as a substitute for genuine reflective practice. The development of a learning organization within the police and the development of positive culture of integrity creating the setting for a duty of candour to flourish has two specific challenges. The first concerns the professional identity of the police and the space to have meaningful critical reflection. The College of Policing was set up as professional body only in 2011 and provides an important stress on standards but does not have the history or developed identity of the healthcare professions. This point is reinforced by the fact that a professional code of ethics was only

instituted in 2014 (Westmarland & Rowe, 2018). Moreover, the implications of this professional code and the development of a related culture are still being worked through, partly through the development of three regional committees focused on the development of codes. A key question, is how can a national/professional culture be developed across three regions representing 45 separate police forces in the UK? The second challenge is to build accountability and the development of better governance. A key development that can help with greater democratic accountability is the election of police commissioners for each force. This too requires review and critical reflection to examine the consequences of these developments (Caless & Owens, 2016).

Returning to the health service, a good example of shared responsibility relates directly to the duty of candour is the shared guidance set out by the medical and nursing professions in the joint publication 'Openness and honesty when things go wrong: the professional duty of candour,' (GMC/NMC June 2015). In addition, there needs to be more inter-professional dialogue about principles, values and practice. In the case of child Jack (Glasper, 2018), there seems to be very different views of justice in how medical and nursing professions have treated the main participants. In this case a doctor and nurse were convicted of negligent practice. Both were also expelled from their professions, though the doctor was later readmitted. The medical profession has shown restorative justice whilst the nursing profession seems to have maintained a position of retributive justice. More critical dialogue between the professions would reinforce both trust and accountability, and thus the communication of the truth.

Similarly, more critical and constructive dialogue between the professions and healthcare management would begin to address misperceptions, focused in and leading to lack of trust. Such lack of trust is exemplified in the different view of NHS management and nursing professions around whistleblowing. A majority of managers believe that whistle blowing reports will be well handled, compared to a minority of nurses (Robinson & Doody, 2021). In developing an architecture of dialogue, this sets up regulative dynamic which complements the governance and statutory regulation. Literally, this focuses on the regulation of mutual accountability (King, 2009).

A key question is, what impact if any has this duty of candour had on healthcare, and healthcare providers, in the context of serious incident reporting? NHS Improvement (improvement.nhs.uk. 2019) has released data indicating the number of serious incidents has increased from 13283 in 2010 to 23333 in 2016, with a spike in 2014 with 31634 reported incidents. It is therefore suggested that the imposition of the duty has had some impact in relation to establishing a culture of openness. How deep this cultural change runs is far from clear, but it's a start and lessons can be learned.

CONCLUSION: CANDOUR AND PUBLIC LIFE

The stress on a culture of integrity with any statutory duty reinforcing this, as a part of a wider, dialogic regulation, can clearly apply to any attempts to develop candour in public life in general and in the arena of justice in particular. The importance of the duty of candour has been reinforced by the courts recently in *PSA v NMC and Another* [2019] EWHC 1181

(Admin) and is a case which is not only important for the NHS, but also the police if such a duty was to be imposed. A three-year suspension order placed on a nurse was reviewed. She dishonestly covered up her findings into a suicidal patient, including at the inquest into the patient's death. The mismatch between the practitioners notes and the deceased's recordings of the interview on the phone was obvious. The Court held that, "anything other than candour would undermine the purpose of the investigation."

This reiterates the earlier points from judicial review cases, but also adds that combined with dishonesty, the failure to be candid will be viewed censoriously. The Covid-19 crisis has shown the key role that the NHS plays in civic society. Duty of candour has had a contested life within the NHS but there are indications that it has had a beneficial impact largely through more open dialogue with other stakeholders to develop a clear sense of mutual accountability and shared responsibility. The challenge for the NHS and the police and other public bodies who may become subject to this type of duty is that this change will only come if there is a foundation of an organizational culture of integrity and a succoring of integrity in public life. This is a space where critical reflection nurtures openness and trust between public bodies and the public they serve.

REFERENCES

Amsterdam Approach to Healthvy Weight (AAGG) City of Amsterdam. (2015). Summary of programme plan. Retrieved from https://www.amsterdam.nl/publish/pages/847273/summary_amsterdam_healthy_weight_programme.pdf

Aristotle (2004). *Nichomachean ethics*. London: Penguin.

Berwick, D. (2013). *A promise to learn–a commitment to act: Improving the Safety of Patients in England.* Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf

Brouwer, J., Van Der Woude, M., & Van Der Leun, J. (2018). Border policing, procedural justice and belonging: The legitimacy of (cr)immigration controls in border areas. *British Journal of Criminology*, *58*(3), 624–643. doi: 10.1093/bjc/azx050

Caless, B., & Owens, J. (2016). *Police and crime commissioners: The transformation of police accountability*. Bristol: Policy Press.

Care Quality Commission (CQC). n.d. Retrieved from https://www.legislation.gov.uk/ukpga/2008/14/notes.

Carr, S. (2008). Editors notebook 'A Quotation with a Life of Its Own'. In *Patient safety & quality healthcare*. Rockville: Agency for Healthcare Research and Quality https://www.psqh.com/julaug08/editor.html.

Case, P. (2017). Regulating health care professionals. In Judith Laing, Jean McHale (eds), *Principles of medical law*, 4th edn. Oxford: Oxford University Press.

Conn, D. (2019). Mayors of Liverpool and Manchester call for 'Hillsborough law.' Retrieved from https://www.theguardian.com/football/2019/dec/03/mayors-of-liverpool-and-manchester-call-for-hillsborough-law

Fallon, P. (1999). Report of the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/265696/4194.pdf

Francis, R. (2013a). *Report of the mid Staffordshire NHS foundation trust public inquiry*.

Francis, R. (2013b). Press Statement. Retrieved from https://webarchive.nationalarchives.gov.uk/20150407085006/http://www.midstaffspublicinquiry.com/sites/default/files/report/Chairman's

Gardiner, S., Parry, J., & Robinson, S. J. (2017). Integrity and the corruption debate in sport: Where is the integrity? *European Sport Management Quarterly*, *17*(1), 6–23. doi:10.1080/16184742.2016.1259246

Glasper. (2018). Retrieved from https://www.tandfonline.com/doi/pdf/10.1080/24694193.2018.1467159)

Green, P. (1990). *The enemy without: Policing and class consciousness in the miner's strike*. Maidenhead: Open University Press.
Hill, A. (2020). UK care home bosses threaten to quit over return of coronavirus patients. Retrieved from https://www.theguardian.com/society/2020/apr/02/uk-care-home-bosses-threaten-quit-over-return-coronavirus-patients
Hillsborough Independent Panel (HIP). (2012). *The Report of the Hillsborough Independent Panel*. London: The Stationery Office.
Hopwood, A. A. (2020). *Tale of two duties*. Retrieved from http://www.professionalstandards.org.uk
Jones, J, the Right Reverand. (2017). 'The patronising disposition of unaccountable power': A report to ensure the pain and suffering of the Hillsborough families is not repeated (London HMSO) HC 511.
Kennedy, I. (2001). *The report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995*, Sir Ian Kennedy, Learning from Bristol (hereafter the Kennedy Report) (Cmnd. 5207-I).
King, M. (2009). *King Report on Governance for South Africa 2009 (King III)*. Sandton: Institute of Directors in Southern Africa.
Kirkup, B. (2015). *The Report of the Morecambe Bay Investigation*. London: The Stationery Office.
MacNamara, J. (2015). *Organizational listening: The missing essential in public communication*. Oxford: Peter lang.
Martin, G., Chew, S., & Dixon-Woods, M. (2019). Senior stakeholder views on policies to foster a culture of openness in the English National Health Service: A qualitative interview study. *Journal of the Royal Society of Medicine*, *112*(4), 153–159. doi:10.1177/0141076818815509
Metters, J. (2003). Isaacs report the investigation of events that followed the death of cyril mark isaacs. ISBN 0 1132 2611 X. London: The Stationery Office.
Moore, G. (2012). The Virtue of Governance, the Governance of Virtue. *Business Ethics Quarterly, 22*(2) 293–318.
NHS Constitution. (2015). Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/480482/NHS_Constitution_WEB.pdf
NMC and GMC. (2020). Openness and honesty when things go wrong: The professional duty of candour. Retrieved from https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/openness-and-honesty-professional-duty-of-candour.pdf
ONeill, O. (2002). *Reith lectures: A question of trust*. Cambridge: Cambridge University Press.
Redfern Michael, Q. C. *The Royal Liverpool Children's Inquiry* (hereafter the Redfern Report January (2001). HC12-II.
Ricoeur, P. (2000). The concept of responsibility, an essay in semantic analysis. In *The Just*. Chicago: University of Chicago Press.
Robinson, S. (2013). Hearing voices: Wisdom, responsibility and leadership. In Thompson, M. and Bevan (Eds.), *Wise management in organisational complexity*. London: Palgrave.
Robinson, S. (2016). *The practice of integrity in business*. London: Palgrave.
Robinson, S., & Doody, O. (2021). *Nursing and healthcare ethics*. London: Churchill Livingstone.
Sanderson, C. (2020). *The Bystander Effect: The Psychology of Courage and Inaction*. London: William Collins.
Scraton (2016). *Hillsborough - the truth*. London, mainstream digital.
Senge, P. (1990). *The fifth discipline: The art and practice of the learning organization*. New York: Random House.
Taylor, Lord Justice. (1989). *The Hillsborough Stadium Disaster: Interim report*. London: The Stationery Office.
Thompson, M. and Bevan D. (Eds.) (2013). *Wise management in organisational complexity*. London: Palgrave.
Undercover Policing Inquiry (UCPI). (2015). https://www.ucpi.org.uk
Walsh, P. (2020). *The Duty of Candour – where are we now?* Retrieved from http://www.professionalstandards.org.uk
Westmarland, L., & Rowe, M. (2018). Police ethics and integrity: Can a new code overturn the blue code? *Policing and Society*, *28*(7), 854–870. doi:10.1080/10439463.2016.1262365
Wood, S., & Gardiner, S. (2019). Policing UK airports and schedule 7 of the terrorism act 2000: The young passengers' perception of security measures. *Terrorism and Political Violence*, 1–22. doi:10.1080/09546553.2019.1638255